

FILED MAY 3 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 1824

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Lakeside Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Days  
(Specify whether  
In this community 3 days  
years, months or days)

3. (a) PRINT FULL NAME Mrs Laura Hunt Yoakum

3. (b) If veteran, name war No  
3. (c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife George Yoakum  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased June 30 th 1855  
(Month) (Day) (Year)

8. AGE: Years 89 Months 9 Days 20  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Annapolis Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business \_\_\_\_\_

12. Name William Hunt

13. Birthplace Unknown N. Carolina  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Williams

15. Birthplace Indianapolis Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs L. J. Shebilsky

(b) Address Overland Park Kansas

17. (a) Burial (b) Date thereof 4-23-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Wilbur W Hoge

(b) Address Overland Park, Kansas

19. (a) 4-23-45 (b) Seraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Johnson  
(c) City or town Overland Park  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7729 Floyd  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20th  
year 1945 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from April 17  
1945 to April 20 1945  
that I last saw her alive on April 19 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death SHOCK

Duration  
3 DAYS

Due to SEMI-PT-Y

Due to FRACTURE OF RIGHT FEWER 3 DAYS

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ACCIDENT

(b) Date of occurrence APRIL 18, 1945

(c) Where did injury occur? OVERLAND PARK, JOHNSON, KANS.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
(HOME) - FELL IN BED ROOM

(Specify type of place) While at work? no (e) Means of injury fall

23. Signature Dr. Chas. P. Scheraga (M. D. or other) P.O.  
Address Overland Park, Kansas Date signed 4-21-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*J. S. Walton*

Licensed Embalmer No. *2744*

P. O. Address *N. C. 7700*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**